Exhibit A

IN RESPONSE TO THE CORONAVIRUS (COVID-19) PANDEMIC, A FEDERAL JUDGE HAS ORDERED THAT CERTAIN MEDICALLY VULNERABLE PRISONERS BE TRANSFERRED OUT OF FCI ELKTON. WE WANT TO KNOW IF YOU ARE PART OF THE GROUP THAT CAN GET TRANSFERRED.

The ACLU of Ohio and the Ohio Justice & Policy Center want to learn who is covered by the Court's order as part of a class action lawsuit. Please fill out this letter only if:

1. You are **65 years old or older** OR
2. You have a **documented** medical condition that puts you at high risk for getting very sick from COVID-19

If you **are** in one of those 2 groups, please:

- Answer the questions on the back AND fill out the attached medical release form
- Put the letter AND the form in the envelope and return it.

If you **are not** in one of those 2 groups, please do not return this letter.

Name:_____

BOP #:_____ Age:_____

Your Current Release Date: _____

Your Lawyer's Name: _____

Your Lawyer's Phone or Email: _____

Check this box only if you do NOT have a lawyer, and you cannot afford to pay for one: ☐

Have you asked the Warden for compassionate release? ☐ Yes ☐ No

If yes, when did you apply? _____

If yes, have you gotten a response? ☐ Yes ☐ No

What response did you get? _____

The ACLU of Ohio and the Ohio Justice & Policy Center are not your attorneys as an individual, though we do seek to represent the class of people seeking transfer, as a whole. If you think you might be eligible for compassionate release, you should contact your lawyer or ask for compassionate release in writing to the Warden.

TURN OVER

Your medically documented, pre-existing condition (*circle all that apply*):

Heart Disease

Liver Disease
(including Hepatitis C)

Kidney Disease
(whether on dialysis or not)

Lung Disease
(including asthma and COPD)

Diabetes

Immunocompromised
(cancer treatment, transplants, HIV/AIDS, or medications that weaken the immune system)

Severe Obesity
(BMI of 40 or higher)

Other/Please Specify: _____

_____

Any details about your condition: _____

_____

What treatment have you had for your condition? _____

_____

_____

Does FCI Elkton have access to medical records for your condition?

☐ Yes ☐ No

If you believe you may have a condition that puts you at risk, it is your responsibility to provide all medical records to the prison so that you can be included. We recommend that you contact your attorney. ***If you choose to provide information using this letter, we may share it with other attorneys, consultants, or attorneys for the Bureau of Prisons as part of our efforts to pursue relief for the class.***

You Have the Right to Opt Out of this Class Action

The judge's order in the class action lawsuit applies to all prisoners age 65 or older OR with medical conditions. These people may be eligible for home confinement, furlough, compassionate release, or transfer out of Elkton to a different prison.

It is possible that the Warden, the Bureau of Prisons, or the court may find that you are not eligible for home confinement, furlough, or release, and that your only choice is to move to a different prison or stay at Elkton. That other prison could be higher security than Elkton, but would be better than Elkton for social distancing. IF THAT HAPPENS, **YOU CAN DECIDE LATER TO STAY AT ELKTON**.

Even though you can opt-out later, would you like to opt out of this class action now anyway? Checking "Yes" means **you would NOT obtain any kind of release or transfer as a result of this lawsuit.**

☐ Yes ☐ No

OJPC ACLU Ohio

AUTHORIZATION AND RELEASE FOR MEDICAL RECORDS

Patient Name: _____

Date of Birth:_____ Social Security Number:_____

I hereby authorize FCI Elkton to disclose my health information, as described below, **to ACLU of Ohio Foundation, 1108 City Park, Ave., Ste. 203, Columbus, OH 43206; and its Cooperating Counsel and Their Staff, including but not limited to the Ohio Justice & Policy Center, 215 E. 9th St., Cincinnati, OH 45202.** The health information to be disclosed is**:**

Any and all medical records held by FCI Elkton, whether they were generated at that facility or elsewhere, including but not limited to hospital records, intake records, progress notes, procedure notes, test results, imaging reports, doctor's reports, nursing reports, prescription records, and diagnosis and treatment records, including for HIV/AIDS.

I understand that my signing or revoking this Authorization will not affect my healthcare treatment, enrollment in a health plan, or eligibility for health benefits. I understand that the Medical Information is confidential and that HIV/AIDS diagnosis and treatment records, and drug and alcohol abuse treatment records are accorded specific protection by federal and/or state laws and regulations. By signing this Authorization, I consent to the disclosure to and use by the Recipient of all Medical Information, including HIV/AIDS diagnosis and treatment records, and drug and alcohol abuse treatment records. You are hereby released from any and all liability in connection with your disclosure of Medical Information to the Recipient. I understand that, except as otherwise stated in this Authorization, information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy laws and regulations.

THIS PARAGRAPH APPLIES ONLY TO A PARTY REQUESTING EITHER HIV/AIDS INFORMATION FROM THE VETERANS ADMINISTRATION OR DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION FROM ANY SOURCE: Prohibition on Redisclosure. This information is being disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person who is the subject of the information or is otherwise permitted by 42 C.F.R. Part 2 or 38 C.F.R. Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.

This authorization is continuing in nature and is to be given full force until this Authorization expires one year after it is signed. Notwithstanding the immediately preceding sentence, I understand that I may revoke this Authorization at any time prior to its expiration by sending written notice of revocation to ACLU of Ohio Foundation, Attn: David J. Carey, 1108 City Park Ave., Ste. 203, Columbus, OH 43206, except to the extent that action already has been taken in reliance on this Authorization.

A copy of this Authorization may be used as an original.

_____ _____

Signature of Patient Date Signed